STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. Building B. Wing	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accordius Health at Rose Manor LLC	4230 North Roxboro Street Durham, NC 27704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with residents, staff and Emergency Medical Technician (EMT), the facility failed to provide care in a safe manner when Resident #1 rolled off the bed to the floor while Nurse Aide #1 provided incontinence care for 1 of 3 residents reviewed for accidents (Resident #1).The findings included:Resident #1 was admitted to the facility on [DATE]. Her current diagnoses included a wound on her left lower leg, anxiety disorder, and arthritis. Review of a social work progress note dated 12/3/25 indicated Resident #1 was cognitively intact.A nursing progress note dated 12/4/25 revealed while Nurse Aide (NA) #1 was changing Resident #1 she rolled out of bed, away from NA #1, and landed on the floor towards the wall. Resident #1 was lying on her left side. Staff were unable to get her off the floor because she was complaining of right knee pain. Emergency Medical Services (EMS) was called. The resident assisted with a lift to the stretcher and was transported to the local emergency department.Review of NA #1's written statement dated 12/4/25 revealed she had provided incontinence care to Resident #1. She reported she was going to assist Resident #1 after a countdown. NA #1 stated the resident pulled on the transfer bar prior to her getting to the window side of the bed. She stated Resident #1's legs went off the bed and then her body followed, with her face hitting the wall and she slid out of the bed. NA #1 stated the resident began yelling for help. She stated she then notified the nurse.A phone interview was conducted with NA #1 on 12/8/25 at 11:45 AM. She explained that when she assisted residents with turning, she would count backwards from three and then turn the resident (3,2, 1, then begin turning the resident). NA #1 stated she was going to assist Resident #1 with turning to provide incontinence care at the count of three. NA #1 stated on 12/4/25 she had not started the countdown from three when Resident #1 placed her left leg over her left foot and fell off the bed while holding the transfer bar. She reported she did not touch the sheet and had not attempted to turn the resident. NA #1 stated she planned to move from one side of the bed to the other prior to turning the resident. She reported she was on the door side of the bed and the resident fell towards the opposite side of the bed. NA #1 stated Nurse #1 came in and assessed the resident. She stated after Nurse #1 assessed Resident #1 she and another nurse aide (NA #2) were going to place the resident back in bed. NA #1 stated when they attempted to get the sling under her to use the lift, Resident #1 complained of knee pain. Nurse #1 then instructed the nurse aides to stop and contacted EMS.Attempts to contact NA #2 were unsuccessful. A statement written by Nurse #1 stated she was approached by NA #1 who stated Resident #1 was on the floor and had rolled off the bed. She assessed the resident who stated she had pain in her knees. She conducted neurological checks, and the resident did complain of pain in her knees of 7 out of 10. Nurse #1 stated she instructed NA #1 and NA #2 to place the resident back in bed. The resident complained of pain while the nurse aides were attempting to place her back in bed, so Nurse #1 decided to contact EMS. A telephone interview was conducted with Nurse #1 on 12/10/25 at 3:42 PM. She reported she assessed Resident #1 on 12/4/25, did not find any injury, and instructed NA #1 and NA #2 to place her back in bed afterwards. Nurse #1 stated Resident #1 began complaining of severe knee pain and she decided to contact 911 to transport Resident #1 to the hospital. Nurse #1 stated she could not comment on the incontinence care as she was unsure of what happened.A phone interview was conducted with Resident #1 on 12/8/25 at 11:32 AM who remained in the hospital. Resident #1 stated she was at the edge of the bed and rolled off when NA #1 pulled the sheet. Resident #1 reported NA #1 was nice the previous evening but appeared short and in a hurry the evening of 12/4/25. She reported she used the transfer bar (a sturdy mobility device designed to provide a secure handhold for individuals entering, exiting, or repositioning themselves in bed) on the side of bed and rolled away from NA #1.An Emergency Medical Technician (EMT) report dated 12/4/25 revealed Resident #1 stated she was dropped from her bed after requesting to do her rehabilitation exercises. She was on a lift mat when EMT staff arrived, and Resident #1 stated she had pain in her head and back. A telephone interview was conducted with Emergency Medical Technician (EMT) #1 on 12/10/25 at 3:00 PM. She stated Resident #1 complained of pain in her head and back.Review of emergency department admission record dated 12/4/25 revealed Resident #1 was evaluated for a fall. She complained upon admission of pain in her upper back, head and knees. A computed tomography scan of her head, an x-ray of her hip and laboratory testing was done for infection. All studies were negative. As of 12/11/25 hospital notes indicated Resident #1 refused to return to the facility and remained in the hospital awaiting an alternate placementAn interview was conducted with the Director of Nursing on 12/8/25 at 3:05